YOUR PATIENT ADVOCATE WANTS YOU TO LEARN HOW TO

Protect Your Group Health Care Coverage

State of California

THE PATIENT ADVOCATE

YOUR VOICE, YOUR HMO RIGHTS

A MESSAGE from the Patient Advocate

This compact booklet provides you with some valuable information on the necessary steps and choices you have to secure your health care coverage. Please take a few minutes to read it and understand its content. If you have any questions about any of the issues discussed here, please contact any of the resources provided at the end of the booklet, or contact the Department of Managed Health Care's website at www.hmohelp.ca.gov. Also, you may contact the California HMO Help Center toll free at 1-888-HMO-2219, or TDD 1-877-688-9891.

About the PATIENT ADVOCATE

A dedicated voice for all Californians enrolled in a Health Maintenance Organization (HMO), the Patient Advocate was appointed by Governor Gray Davis to lead an independent and autonomous office under the Business, Transportation and Housing Agency. The Patient Advocate informs managed health care consumers about their HMO rights under California law and helps assure the highest level of consumer service at the California HMO Help Center within the Department of Managed Health Care.

SECURE Your Health Care Coverage

It is important to take immediate action to secure your group health coverage when you experience a change in job status. If you switch jobs, lose a job, or have your work hours reduced, you may be at risk for losing your group health coverage. This risk becomes even greater for people with health problems, as many health insurance companies and health plans will not accept new members who have existing health conditions. These conditions are referred to as "pre-existing conditions" and may sometimes be used to deny coverage.

Through some special programs, California and federal law now offer valuable protection for people in these situations. Each one of these laws requires that you take action to receive the benefits. Also, these programs follow one another in a certain order. If you qualify for a program but fail to sign up for it, you will lose the program benefits and you will lose the chance to enroll in the next subsequent program. So please read the following notes carefully, and call the contacts listed below if you have additional questions.

The order in which to consider the programs is as follows:

① Federal COBRA or Cal-COBRA
② Senior COBRA
③ HIPAA
④ Conversion coverage

CAL-COBRA

The first step in finding out if you may keep your employer's group coverage when you are in danger of losing it is to see if you are eligible for either federal COBRA or Cal-COBRA. Federal COBRA applies to employers who have 20 or more employees. It is governed by federal law. (For additional information about Federal COBRA, use the contacts listed under "Additional Information.") Cal-COBRA is available under California law and applies to small employers who have 2 to 19 employees.

The Department of Managed Health Care is responsible for seeing that health maintenance organizations (HMOs or health plans) in California provide Cal-COBRA coverage as required by law.

The idea of Cal-COBRA is to provide the same general advantages to small groups in California as Federal COBRA provides to larger groups. The main advantages are: (1) the right to keep your group coverage under certain conditions when it might otherwise end, and (2) the right to keep nearly the same premium rates as the employer group has. The important difference in premiums is that your employer will no longer be making a contribution to the payment of your insurance premium, and you will have to pay the entire premium yourself.

WHO Can ENROLL in CAL-COBRA

In order for someone to enroll in Cal-COBRA, one of the following situations, called "qualifying events," has to occur:

- Loss of coverage because employment of the covered employee ends (unless employment ends because of gross

misconduct of the employee), or loss of coverage because the hours of the covered employee's employment are reduced
- Loss of coverage because of divorce from the covered employee
- Loss of coverage because one is no longer a dependent of the employee under the group plan
- Loss of coverage because the covered employee has become eligible for Medicare
- Loss of coverage because of the death of the covered employee

Who CANNOT ENROLL in CAL-COBRA

You are not eligible for Cal-COBRA if you are one of the following:

- Eligible for Medicare
- Covered by another group health plan, unless:
  - — that other group health plan has a pre-existing condition exclusion or limitation that applies to you, or
  - — that other group health plan is a group conversion plan (basically the offer of an individual plan) that you choose not to accept
- Terminated from employment because of gross misconduct
- Someone who fails to choose Cal-COBRA in writing when it is available
- Someone whose allowed eligibility period has been used up

BENEFITS Under CAL-COBRA

Anyone covered under Cal-COBRA has the same benefits as active covered employees. If active employees have open enrollment periods when they can change from one plan to another,

Cal-COBRA enrollees may do the same. If the employer changes the employees from one plan to another, the Cal-COBRA enrollee must be allowed to transfer into the new group along with active covered employees. No restrictions based on pre-existing conditions are allowed. If the group plan offers special coverage, such as dental or vision coverage, that must be provided to the Cal-COBRA enrollee as well.

CHOOSING to Have CAL-COBRA

If your employment ends or your hours are reduced, your employer must notify both you and the health plan that a qualifying event occurred. If you have any other qualifying event, you should notify both the employer and the health plan. Within 60 days of the qualifying event, you must notify the health plan in writing that you want to enroll in Cal-COBRA. The 60 days do not start to run until you receive notice that Cal-COBRA is available.

The health plan then must send you a premium notice and information within 15 days about completing the enrollment. (There may be a part of the group contract that requires the employer rather than the plan to send you the notice.) The health plan agreement or contract booklet that explains your health plan benefits, often called an Evidence of Coverage or Summary Plan Description, contains information about Cal-COBRA as well.

Premiums must be paid when due. There is no break in your coverage if you enroll and pay on time.

The TIME Period for Continuing Coverage under CAL-COBRA

If a former employee receives Cal-COBRA coverage because employment ended or because working hours were reduced, Cal-COBRA for the former employee, spouse, and dependents may continue for up to 18 months.

If the former employee's spouse or dependent receives Cal-COBRA coverage because of any of the following reasons, their coverage may continue for up to 36 months:

- death of the former employee
- divorce from the former employee
- the former employee becomes eligible for Medicare
- the dependent is no longer considered a dependent under the group plan

Certain people found eligible for Social Security Disability may be eligible for up to 29 months.

A Small EMPLOYER'S Responsibilities Under CAL-COBRA

Small employers have a duty to do all of the following under Cal-COBRA:

- Notify the health plan in writing, within 30 days of termination or reduction in hours, that the person is eligible for Cal-COBRA
- Refer the eligible person to the health plan to start the Cal-COBRA coverage or manage the enrollment for the person
- In case the employer changes from one health plan to another group plan, it must promptly notify all persons currently on Cal-COBRA that they have a right to continue coverage with the new group plan. The employer must also give the new group plan the names of all persons on Cal-COBRA so the new plan can offer the coverage as it is required to do.

When CAL-COBRA ENDS

Cal-COBRA will end as soon as one of the following happens:

- The time period stated in the law passes (usually 18 or 36 months)
- Premiums are not paid when due
- The covered person moves outside the health plan's service area
- The employer no longer offers any health coverage to its employees
- The covered person becomes eligible for Medicare
- The covered person enrolls in another group policy

If the end of Cal-COBRA comes because the legal time period has been used up, the health plan must notify the enrollee when the end of coverage is coming. It must offer any additional continuation benefits that might be available under Senior COBRA. If Senior COBRA is not available, the plan must determine if the enrollee is eligible for individual coverage under HIPAA. Finally, if the enrollee is not eligible for one of these programs there may be conversion rights that are available through the plan.

SENIOR COBRA

If you have either Federal COBRA or Cal-COBRA and your time period for coverage is about to be used up, you should check to see if you are eligible for an extension of your COBRA benefits under what is commonly called "Senior COBRA." Senior COBRA is provided for under state law.

Who CAN Enroll in SENIOR COBRA

A former employee who was at least 60 years old at the time employment ended, and who had worked for the employer for at least five years, may be eligible for Senior COBRA. The former employee's spouse, and any former spouse, may also continue coverage.

Who CANNOT Enroll in SENIOR COBRA

You are not eligible for Senior COBRA if you are one of the following:

- A former employee whose employment ended because of gross misconduct
- Eligible for Medicare
- Sixty-five years old or older
- Someone covered by another group health plan
- Someone who did not choose COBRA when it was available to you
- Someone who fails to choose Senior COBRA in writing when it is available
- Someone whose allowed eligibility period has been used up

BENEFITS Under SENIOR COBRA

Anyone covered under Senior COBRA continues the same basic health care benefits as were available under Federal COBRA or Cal-COBRA. No restrictions based on pre-existing conditions are allowed. Specialized health care service plans, such as dental or vision plans, are not required to offer Senior COBRA.

CHOOSING SENIOR COBRA

As the end of your COBRA or Cal-COBRA approaches, your employer or the health plan must notify you of the availability of Senior COBRA. You must notify the health plan, **in writing**, within 30 days of the end of your coverage that you wish to continue coverage under Senior COBRA.

The TIME PERIOD for Continuing Coverage under SENIOR COBRA

Benefits may last up to five years or until one of the following events occurs:

- The individual turns 65
- The individual becomes Medicare eligible
- The individual does not pay premiums
- The employer no longer offers health coverage to any active employees

HIPAA

If you are not eligible for COBRA or Senior COBRA, or if the end of COBRA or Senior COBRA comes and you are not yet eligible for Medicare, the Health Plan must determine whether or not you are eligible for HIPAA. HIPAA is the short name for the Health Insurance Portability and Accountability Act, a federal law. HIPAA may also benefit you if you change jobs and start new insurance with your new employer, or if you leave your group health plan and become self-employed.

Different rules apply depending on whether a person is eligible under the Group Market Provisions or the Individual Market Provisions. In California, there are additional protections beyond what HIPAA requires. For example, California limits the amount of the premiums that may be charged.

The basic idea behind HIPAA is that health insurance must be "portable," that is people should be able to carry around their eligibility for health insurance coverage from one job to another. Another HIPAA principle is that people should not be discriminated against because of the condition of their health. Therefore, insurance companies and health plans cannot deny coverage to new employees who have a pre-existing condition if they are otherwise eligible for health insurance.

Insurance companies and health plans often require waiting periods for coverage, and they may exclude some kinds of benefits. Under HIPAA, the waiting periods may be reduced or eliminated for some people.

Eligibility for HIPAA coverage does not guarantee that people will have the same package of health care benefits or the same premiums they had in their old jobs. Group premiums and individual premiums may not be the same. You should compare benefits and premiums under HIPAA coverage with what you would get in a conversion policy, if you are eligible for one.

If you expect to change jobs, you should check your current benefits with your employer to see what kind of coverage you have. You also should ask your new employer to provide you with an explanation of how HIPAA will apply to you. Your health plan must also help you find out if you are eligible for HIPAA.

For additional information about HIPAA go to www.hcfa.gov and click on HIPAA on the home page. You may also call the Department of Managed Health Care at 888-HMO-2219.

CONVERSION COVERAGE

Under certain circumstances, when your group coverage ends, your health plan must offer you individual coverage without limits due to pre-existing conditions. Check your Evidence of Coverage for a description of any rights you may have. Premiums are not limited for conversion health plan coverage, therefore you may want to review the terms of this coverage carefully if there are other programs available to you.

WHERE to Obtain Additional INFORMATION

- **If you are a member of a health care service plan (HMO),** call the Department of Managed Health Care. The Department was established in July 2000 under the Business, Transportation and Housing Agency to regulate many California health plans. Within the Department is the HMO Help Center, which provides individual support and guidance to enrollees with problems that they have not been able to resolve with their health plan. The toll-free number is (888) HMO-2219, TDD (877) 688-9891 or you may obtain more information through the Department's website: www.hmohelp.ca.gov.
- **If you have traditional indemnity insurance (non-HMO, fee-for-service),** contact the Department of Insurance toll-free at (800) 927-4357.
- **If you are a member of a self-insured group health plan** (the employer pays the employees' health care bills), contact the U.S. Department of Labor, Pension and Welfare Benefits Administration at (626) 583-7862 (Southern California) or (415) 975-4600 (Northern California).
- **If you belong to an employer group** with 20 or more employees and have questions regarding Federal COBRA,

contact the U.S. Department of Labor, Pension and Welfare Benefits Administration at (626) 583-7862 (Southern California) or (415) 975-4600 (Northern California).

- **For additional information about HIPAA,** contact the Department of Managed Health Care at (888) HMO-2219 or go to www.cms.hhs.gov on the Internet and click on HIPAA now located on the bottom of the home page.
- **If you are not eligible for HIPAA** or a conversion policy, the California Major Medical Insurance Program (MRMIP) offers health insurance to individuals who have been rejected for individual health coverage by a health plan. Contact the Program at (800) 289-6574.
- **If you are 65 years old or disabled** and have a question regarding Medicare, contact the Health Insurance Counseling and Advocacy Project (HICAP) at (800) 434-0222.

Notice: We attempt to make descriptions of the law accurate as of the date of publication. However, the descriptions are only summaries and not definitive statements of law. Questions about the law's application to a particular case should be directed to an attorney. Complaints relating to coverage issues should be directed to the Department of Managed Health Care's toll-free number (888) HMO-2219.

Flex your POWER℠

GET HELP NOW

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